DCH/LNR-502 (03/04)

Michigan Department of Community Health
Board of Nursing
P.O. Box 30193
Lansing, Michigan 48909
(517) 335-0918

PRACTICAL NURSE LICENSURE INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Nursing. Questions regarding your application can be directed to the Michigan Board of Nursing at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned.

INSTRUCTIONS FOR COMPLETING THE APPLICATION

1. You must submit the application for licensure, all supporting documents requested, and the appropriate fee to the Board of Nursing to determine your eligibility to sit for the exam. **ELIGIBILITY FOR THE EXAM IS DETERMINED SOLELY BY THE MICHIGAN BOARD OF NURSING, AND IS SEPARATE FROM REGISTERING FOR THE EXAM WITH PEARSON PROFESSIONAL TESTING (PPT).**

2. Read all instructions carefully and answer all questions on the application including providing details on a separate sheet if necessary. Failure to correctly complete the application in its entirety may delay the processing of your application.

3. Provide all information requested on the application. **YOUR NAME MUST APPEAR EXACTLY AS IT IS ON THE PICTURED I.D. YOU WILL BE USING TO TAKE THE EXAMINATION** *(Driver's License, State I.D., Passport, Immigration Card)***.**

4. A Michigan licensure application accompanied by the appropriate fee is valid for three years. If an applicant fails to complete the requirements for licensure within three years from the date of filing the application, the application is no longer valid.

5. School Certification--Michigan graduates must have the school submit a Michigan Nursing School Certification form directly to the Michigan Board of Nursing. Out of state graduates must have the school submit transcripts to the Michigan Board of Nursing. Foreign graduates must have the school submit a Credentials Form (attached) and transcripts to the Michigan Board of Nursing. **IT IS YOUR RESPONSIBILITY TO HAVE EVERYTHING SENT TO THE BOARD OF NURSING.** *(Questions regarding your application can be directed to the Michigan Board of Nursing at 517-335-0918 three weeks after the date you sent the application.)*

6. Foreign graduates whose nursing education was not in English, must pass both the TOEFL and TSE exams administered by the Educational Testing Service (ETS). Applicants must have obtained at least a 550 on the Written Test of English as a Foreign Language (TOEFL) or at least 213 on the computerized TOEFL. Applicants must have obtained not less than 50 on the Test of Spoken English (TSE). Information about both exams is available on the web at www.toefl.org.

7. You must complete the NCLEX Examination Application and submit it to Pearson Professional Testing (PPT) by either using the address shown on the form or calling PPT at 1-866-496-2539. You may also register for the NCLEX examination on the Internet at www.vue.com/nclex. The NCLEX Bulletin can be downloaded at www.ncsbn.org. You will be sent an Authorization to Test by PPT along with instructions for scheduling your testing appointment **after** you have been made eligible to take the test by the Michigan Board of Nursing. Once you have received your Authorization to Test, you must sit for the examination within 90 days.

8. Passing letters will not be mailed to those who have passed the examination. If you receive a license, you have passed the examination. Those who are not successful will receive a breakdown of their scores.

GENERAL INFORMATION

1. ***If you require special testing accommodations because of a disability, you must submit a letter that indicates what your disability is and what type of accommodations you are requesting. In addition, we require that you send us a letter from a licensed health care provider that clearly states your diagnosis and includes copies of all supporting test findings and/or evaluations. In addition, you should send us documentation from your nursing program that describes what type(s) of accommodations were provided to you during your education. These documents need to be submitted at the same time you send in this license application, if not earlier, to: DCH, Bureau of Health Professions, Attn: ADA Request, P.O. Box 30670, Lansing, MI 48909.***

2. NAME AND/OR ADDRESS CHANGES: If your name and/or address changes before the exam date, notify the Board of Nursing in writing. Include your former name, address, social security number, and whether or not you are a candidate for the nursing examination with the new name and/or address. Telephone calls are NOT accepted for these changes. Name and address changes can be faxed to (517) 373-2179.

3. REFUND POLICY: If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Nursing in writing to request a refund.

4. Applicants for a Michigan practical nurse license must take the NCLEX-PN within 2 years of graduation from an approved practical nurse education program. Applicants must pass the NCLEX-PN within 12 months of his or her first attempt at the test in Michigan or any other state. If the NCLEX-PN is not passed within this 12-month period, the applicant must complete another entire approved practical nurse education program. After repeating the education program, the applicant may take the examination 3 more times. An applicant has a maximum 6 attempts to pass the NCLEX-PN.

SINCE ALL NURSING LICENSES EXPIRE ON MARCH 31, ORIGINAL LICENSES ARE VALID TO THE FIRST MARCH 31 WHICH MAY BE A YEAR OR LESS; SUBSEQUENT RENEWALS ARE GOOD FOR A TWO-YEAR PERIOD.

DCH/LNR-020 (03/04)

Michigan Department of Community Health
Board of Nursing
P.O. Box 30193
Lansing, MI 48909
(517) 335-0918

APPLICATION FOR PRACTICAL NURSE LICENSE

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, a license will not be issued.

Type or Print Only

Board Use Only

License Number

Date of Licensure

I AM APPLYING FOR THE FOLLOWING:

❒ **License by Examination - Fee: $48.00 71-4703-156**

Your check or money order drawn on a US financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH**. Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name

U.S. Social Security Number	Date of Birth	MI Permanent I.D. Number and Expiration Date, if applicable

Street Address

City	State	ZIP Code

Daytime Telephone Number	All Previous Names and/or Birth Name Used (If Applicable)

Have you ever held a health professional license in Michigan?

☐ Yes ☐ No

School of Nursing	City and State	Date of Completion

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. **Have you ever been convicted of a felony?** ❒ Yes ❒ No
2. **Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?** ❒ Yes ❒ No
3. **Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?** ❒ Yes ❒ No
4. **Have you been treated for substance abuse in the past 2 years?** ❒ Yes ❒ No

Name

Check the appropriate answer to each of the following questions.

NOTE: Attach a detailed explanation for any Yes answer you check.

5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period? ☐ Yes ☐ No

6. Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period? ☐ Yes ☐ No

7. Have you ever had a federal or state health professional license or registration revoked, or otherwise disciplined; been denied a license; or currently have disciplinary pending against you? ☐ Yes ☐ No

8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? ☐ Yes ☐ No

9. Have you ever filed an R.N. or P.N. application in Michigan? ☐ Yes ☐ No

10. Have you ever applied for or written a P.N. exam in another U.S. Jurisdiction? ☐ Yes ☐ No

11. Do you hold or have you ever held a P.N. license or registration in Michigan or any other state? ☐ Yes ☐ No
If yes, list each state, the license or registration number, the date issued, and how the license was obtained (either endorsement or examination). **DO NOT LIST TEMPORARY LICENSES. You must have each state board verify licensure directly to this board office.**
(Attach additional sheets if necessary.)

State	License/Registration Number	Date of Issue	How obtained (Endorsement or examination)

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Michigan Department of Community Health

DCH/LNR-030 (03/04)

Board of Nursing

P.O. Box 30193
Lansing, MI 48909
(517) 335-0918

CREDENTIALS FORM

Authority: Public Act 368 of 1978, as amended.
If this form is not completed for foreign nurse graduates, a license will not be issued

INSTRUCTIONS: This form must be completed by a nursing school for each foreign graduate seeking a license. Please identify areas of classroom instruction and clinical experience from the applicant's program in the subjects listed below. **Please sign and seal the completed form and mail with a copy of the applicant's final transcripts to the address indicated at the top of this form.** This form must be completed in its entirety; incomplete forms will be returned.

First Name	Middle Name	Last Name

U.S. Social Security Number	Date of Birth	Please Check Appropriate Box ☐ L.P.N. ☐ R.N.

Five Areas of CLASSROOM Instruction:	Course Titles and Numbers:
1. MEDICAL	
2. SURGICAL	
3. OBSTETRICS	
4. PEDIATRICS	
5. PSYCHIATRIC	

Five Areas of CLINICAL Instruction:	Course Titles and Numbers:
1. MEDICAL	
2. SURGICAL	
3. OBSTETRICS	
4. PEDIATRICS	
5. PSYCHIATRIC	

Was the Nursing Program taught in the English language? ☐ Yes ☐ No

Name of Educational Institution

I certify that _____ attended the
(Applicant's Name)

educational institution named above from _____, to _____, and
(Month/Day/Year) (Month/Day/Year)

was granted a _____ degree on _____.
(Level) (Graduation Date)

_____ _____
Authorized Signature of Program Representative Date of Signature

_____
Print or Type Name of Program Representative

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

OHS/HLD-001 (01/04)

Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909

VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.

- ☐ Chiropractic
- ☐ Counseling
- ☐ Dentistry
- ☐ Marriage & Family Therapy
- ☐ Medicine
- ☐ Nursing
- ☐ Nursing Home Adm.
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Osteopathy
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Physician's Assistants
- ☐ Podiatry
- ☐ Psychology
- ☐ Sanitarians
- ☐ Social Work
- ☐ Veterinary

First Name	Middle Name	Last Name
Previous Names Used	**Date of Birth**	**U. S. Social Security Number**
State Board	**License Number**	**Date of Issue**

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State.
Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Basis for Issuance of License:
☐ Examination - Please indicate type of exam (National, Regional, State, etc.)
☐ Endorsement - Please indicate name of state

Type of License:

License Status	Original Issue Date	Expiration Date
☐ Current ☐ Lapsed ☐ Inactive		

Has the applicant incurred any formal or informal actions in your State?
☐ No ☐ Yes - If Yes, Please attach certified copies of any actions.

Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?
☐ No ☐ Yes	☐ No ☐ Yes

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

_____ _____
Signature **Date**

_____
Type or Print Name

(S E A L)

_____
Title

_____
Full Name of Licensing Board

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.